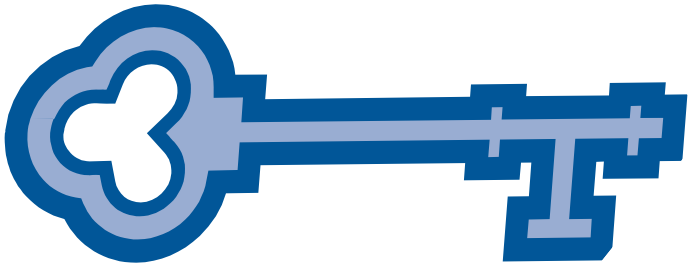
Benefit Choice Options

The Key to Understanding Your Benefits



Local Government Health Plan

Department of Central Management Services
Bureau of Benefits

Effective July 1, 2003 - June 30, 2004

Rod R. Blagojevich, Governor
Michael M. Rumman, Director

Important Changes For Fiscal Year 2004

The information below presents significant changes to the Local Government benefit plans. Please carefully review all the information in this Benefit Choice Options booklet. **This annual Benefit Choice Options Booklet contains updates to the Local Government Health Plan Benefits Handbook.** Members should review this publication each year to be aware of changes in the benefits available. Benefit Choice is May 1-31, 2003. All selections made during Benefit Choice will be effective July 1, 2003.

Changes that impact all Members

Telephone Enrollment will not be available this plan year. If you need to make benefit changes, contact your unit Health Plan Representative for information.

Life Changing Events - If you have a life changing event such as marriage, divorce, etc., contact your unit Health Plan Representative to understand how your coverage may be impacted.

Health Insurance Portability and Accountability Act (HIPAA) - Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

The Department of Central Management Services, Bureau of Benefits contracts with Business Associates (health plan administrators, Health Maintenance Organizations and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavorial health services and prescription drug benefits.

If you have insured health coverage such as an HMO, you will receive a Notice of Privacy Practices from the respective plan administrator. If you are a plan participant in the LCHP, refer to page 23 for the Notice of Privacy Practices.

Changes specific to Managed Care Plans (HMO/OAP)

Plans no longer available - Humana HMO and Humana POS are no longer available. If you are enrolled in one of these plans, you will need to enroll in another managed care plan or in the Local Care Health Plan (LCHP). **If you do not make another plan selection before May 31, 2003, you will automatically be enrolled in LCHP effective July 1, 2003.** Information on the managed care plans will be mailed to your home. For details on plans in your area, see pages 11 - 12.

Changes specific to the Local Care Health Plan (LCHP)

The LCHP Hospital Preferred Provider Organizations - will include 228 hospitals statewide including 3 additions and 6 deletions of providers. Refer to pages 19 -22 for a complete listing.

Changes specific to the Local Government Dental Plan (LGDP)

CompDent has changed their name to CompBenefits. Refer to page 27 for details.

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Member Responsibilities

It is each Member's responsibility to know the benefits. Read the information on the plan in which you are currently enrolled or in which you are considering enrolling.

If you are unsure if an event occurs that your Health Plan Representative needs to know about, it is in your best interest to contact them for assistance.

Notify your Health Plan Representative immediately when the following life changing events occur:

- You and/or your dependents have a change of address.
- You experience life changing events that may affect eligibility for you or your dependent(s) such as:
  - birth/adoption of a child,
  - marriage, divorce, legal separation, annulment,
  - death of spouse or dependent,
  - an employment status change for you, your spouse or your dependent(s) that affects eligibility under the plan,
  - dependent(s) loss of eligibility,
  - a court order results in the gain or loss of a dependent,
  - a change in a Public Aid recipient status,
  - dependent becomes covered by other group health or dental coverage.
- You have other group insurance coverage, or gain other coverage during the plan year. Provide your Coordination of Benefit (COB) information to your Health Plan Representative as soon as possible.
- There is a change in Medicare status for you or your dependent(s).

To ensure that all information is up-to-date, Members should periodically review the following:

- Annual Benefit Choice Booklet which details changes affecting all benefit programs each plan year.
- Health and dental information from plans you are currently enrolled in or are considering enrolling in.
- Prescription formulary list. **Remember:** Formularies are subject to change during the plan year without notice.

Benefit Choice Period is May 1-31, 2003

Benefit Choice Period is the time of year to review and/or make changes to your health benefit plan. Benefit Choice is the **only** time, other than a qualifying change in status, that members can change plans or add/drop dependent coverage (see Benefits Handbook).

Benefit Choice runs from **May 1 through May 31, 2003.** The plan selections elected during this period will be in force for the plan year July 1, 2003 through June 30, 2004.

All Benefit Choice changes can be processed through your Health Plan Representative. If you are unsure who your Health Plan Representative is, contact your Unit's personnel office. Members who do not anticipate making a health plan change should carefully review plan coverages and benefits for possible changes. **Remember: There can be changes in your coverage even if you do not change plans. It is each member's responsibility to review this Benefit Choice Options Booklet in its entirety.**

Whether to consider a change in your benefit plan, or to simply compare your current plan to another, review the features below. They will help you determine the best healthcare choices for you and your family. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider selection process
- Prescription drug coverage

The Local Care Health Plan (LCHP) is available regardless of your place of residence. Managed care plans have geographic and provider limitations. Members interested in a managed care plan should carefully review each plan's benefits, the service area map and county list on pages 11 and 12 and the provider directories available from each plan. Specific questions regarding coverage should be directed to each respective plan administrator.

- **Managed Care Plans**
  HMO – Health Maintenance Organization
  OAP – Open Access Plan
- **Local Care Health Plan**
  LCHP – a medical indemnity plan

For information specific to participating managed care plans, contact the individual plans listed on page 36. For detailed information on the LCHP, refer to your Benefits Handbook. **It is your responsibility to know your benefits.** Read all information on the plan in which you are currently enrolled or in which you are considering enrolling.

Frequently Asked Questions (FAQs) about Benefits

1) Who do I contact for more information about my benefits or to make changes to my existing coverage?

Contact the Health Plan Representative at your employing Unit . Your Unit's personnel or payroll office can assist you in locating your Health Plan Representative.

2) Do I get a new medical and prescription drug identification card every plan year?

Normally, the only times you will receive an identification card are when you first enroll in the plan, if you change plans, if the plan administrator changes or if you request new cards. If you lose your identification card, you may request a replacement card from your plan administrator listed on pages 36.

3) I know managed care plans have geographic limitations. Will I have to change plans if I move?

If your current plan is available at your new location, you will remain under that plan unless your Primary Care Physician (PCP) is not accessible to you. Your managed care plan determines whether you continue to be accessible. If your PCP is not accessible to you, you will need to select a new PCP or change plans. If you move out-of-state or out of the country, you will most likely have to enroll in the LCHP.

4) Is enrollment for my newborn for health coverage automatic?

Enrollment for a newborn is <u>not</u> automatic. To enroll a newborn, contact your Health Plan Representative within 60 days of birth for coverage to be retroactive to birth. The newborn's birth certificate is required for enrollment.

5) What should I, or my dependent, do when we turn 65 and become eligible for Medicare?

Send a copy of the Medicare card to your Health Plan Representative.

6) I (or my dependent) have just become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD), but I am not yet 65 or retired. What should I do and how will this affect my coverage?

First, send a copy of your Medicare card to your Health Plan Representative indicating whether you are receiving Medicare Disability or Medicare ESRD. Depending on the type of Medicare you are eligible for and the length of time you have been entitled to it, your Local Government Health Plan coverage may or may not be your primary payer. If you have questions about the coordination of benefits process with Medicare, you can call the Group Insurance Division, Member Services Section at (217) 558-4486.

7) My address has changed. What should I do?

Contact your Health Plan Representative as soon as possible to update your insurance records.

8) Under what circumstances must I notify my health plan before receiving services?

Notification is required for any hospital or skilled nursing admission, certain outpatient procedures, potential transplants, infertility treatments and maternity care (by the third month). See page 15 for more information.

Managed Care Plans

There are 7 managed care plans from which to choose. Plans include Health Maintenance Organizations (HMOs) and an Open Access Plan (OAP). All offer comprehensive benefit coverage.

There are distinct advantages to selecting a managed care health plan – namely, lower out-of-pocket costs and virtually no paperwork. Like any health plan option, managed care has its limitations including geographic availability and limited provider networks. Members considering managed care are urged to explore and research the various plans available to them.

Health Maintenance Organizations (HMOs)

HMOs operate on an "in-network" structure. Members select a Primary Care Physician (PCP) from the HMO's network of participating providers. In conjunction with the health plan, the PCP directs **all** healthcare services for the member, including visits to specialists and hospitalizations. When care is coordinated through the PCP, the member pays only a predetermined copayment. There are no annual plan deductibles for HMO plans. The minimum levels of coverage HMO plans are required to provide are described on page 8.

Open Access Plan (OAP)

The unique feature of the OAP is that there are three benefit levels as shown in the table on page 9. The program offers two managed care networks, a Tier I network and a Tier II network. In addition, Tier III benefits (out-of-network) are available, so you can have great flexibility in selecting care providers. The important thing to remember is the level of benefits you receive is determined by the selection of care providers.

The benefit level for hospitals, physicians and other services will be highest if you select a Tier I provider - often a 100% benefit after a copayment. The Tier II network is generally a 90% benefit. The Tier III benefits (out-of-network) is generally 80% of Usual &Customary (U&C). See the table on page 9 for more details. The plan provider directory contains separate listings of providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive. Another advantage of selecting the network providers is that they have met strict accreditation standards.

It is important to know that you can mix and match providers. For example, you can utilize a Tier II physician and receive care in a Tier I hospital. In this example, your physician claim would be payable under Tier II at a 90% benefit and the hospital would be paid at the Tier I 100% benefit.

In considering the OAP, compare all benefits to other options. There are important similarities and differences in benefits for prescription drug coverages and mental health/substance abuse services, as well as hospital, physician and other services.

HMO Benefits

The benefits described below represent the minimum level of coverage the HMO is required to provide. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. It is your responsibility to know and follow the specific requirements of the HMO plan you select.

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $200 copayment
Alcohol/substance abuse* *(maximum number of days determined by the plan)*	100% after $200 copayment per admission
Psychiatric admission* *(maximum number of days determined by the plan)*	100% after $200 copayment per admission
Outpatient surgery	100% after $150 copayment
Diagnostic lab & X-ray	100%
Emergency room hospital services	100% after $150 or 50% copayment, whichever is less
Professional and Other Services	
Physician office visits (including well baby care)	100% after $20 copayment
Preventive Services (including immunizations, allergy testing and treatments)	100% after $20 copayment
Psychiatric care* *(maximum number of days determined by the plan)*	100% after $20 or 20% copayment per visit
Alcohol and substance abuse care* *(maximum number of days determined by the plan)*	100% after $20 or 20% copayment per visit
Prescription drugs	$5 generic, $10 brand and $25 non-formulary copayment . Formulary is subject to change during the plan year.
Durable medical equipment	80% of network charges for covered services
Home health visits	100% after $20 copayment per visit

** HMOs determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Each plan must provide for a minimum of 10 inpatient days and 20 outpatient visits per plan year. These are in addition to detoxification benefits which include diagnosis and treatment of medical complications.*

Some HMOs may provide benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage the OAP is required to provide. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. It is your responsibility to know and follow the specific requirements of the OAP plan.

Benefit	Tier I Benefit	Tier II Benefit	Tier III (Out-of-Network Benefit)
Plan Year Maximum Benefit	Unlimited	Unlimited	$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	$1,000,000
Annual Out-of-Pocket Maximum • Per Individual Enrollee • Per Family	 $0 $0	 $1,000 $2,500	 $2,000 $5,000
Annual Plan Deductible *Must be satisfied for all services*	$0	$300 Per Enrollee*	$500 Per Enrollee*
Hospital Services			
Inpatient	Full coverage after $200 copayment per admission	90% of network charges for covered services after $250 copayment per admission	80% of U&C for covered services after $350 copayment per admission
Inpatient Psychiatric	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $200 copayment per admission, up to 30 days per plan year	90% of U&C for covered services after $200 copayment per admission, up to 30 days per plan year
Inpatient Alcohol and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $200 copayment per admission, up to 10 days rehabilitation per plan year	90% of U&C for covered services after $200 copayment per admission, up to 10 days rehabilitation per plan year
Emergency Room	Full coverage after $150 copayment	90% of network charges for covered services after $150 copayment	80% of U&C for covered services after lesser of $150 copayment, or 50% of U&C
Outpatient Surgery	Full coverage after $150 copayment	90% of network charges for covered services after $150 copayment	80% of U&C for covered services after $150 copayment
Outpatient Psychiatric and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $20 copayment, up to 30 visits per plan year	90% of U&C for covered charges after $20 copayment, up to 30 visits per plan year
Diagnostic Lab & X-Ray	Full coverage	90% of network charges for covered services	80% of U&C for covered services
Physician and Other Professional Services			
Physician Office Visits (including well baby care)	Full coverage after $20 copayment	90% of network charges for covered services after $20 copayment	80% of U&C for covered services
Preventative Services (including immunizations, allergy testing and treatment)	Full coverage after $20 copayment	90% of network charges for covered services after $20 copayment	Covered In-network only
Other Services			
Prescription Drugs - Covered in-network only through Wellpoint Pharmacy Management • **Generic -** Full coverage after $5 copayment • **Non-Formulary -** Full coverage after $25 copayment		• **Brand -** Full coverage after $10 copayment	
Durable Medical Equipment	80% of network charges for covered services	80% of network charges for covered services	80% of U&C for covered services
Skilled Nursing Facility	80% of network charges for covered services	80% of network charges for covered services	Covered In-network only
Transplant Coverage	Full coverage	80% of network charges for covered services	Covered In-network only
Home health visits	100% after $20 copayment per visit	90% of network charges for covered services after $20 copayment	Covered In-network only

* **Annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan copayments do not count toward the out-of-pocket maximum.**

Important Reminders About Managed Care Plans

Provider Network Changes: Managed care plan provider networks are subject to change. **Always call the respective plan to verify participation of particular providers** - even if the information is printed in the plan's directory. The provider network is subject to change.

PCPs Leaving a Network: If your PCP leaves the managed care plan's network, you have three options: 1) choose another PCP within that plan; 2) change managed care plans; or 3) enroll in the Local Care Health Plan. The opportunity to change plans applies to **Primary Care Physicians only leaving the network.** It does not apply to specialists or women's healthcare providers who are not designated Primary Care Physicians.

Out-of-County Managed Care Plans: If you are interested in enrolling in a managed care plan that is not available in your county of residence, contact the plan directly for more information.

Dependents: Eligible dependents who live apart from the member's residence for any part of a plan year may be subject to limited service coverage. If you have such a dependent, it is critical to contact the managed care plan that you are considering to understand the plan's guidelines on this type of coverage.

June/July Hospitalizations: If you change health plans and you or your dependents are hospitalized in June, it is recommended you contact both your current plan/PCP and future plan/PCP well in advance.

Psychiatric/Substance Abuse Treatment: Managed care plans determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Plan benefits may vary, but a minimum of 10 inpatient days and 20 outpatient visits are required. These are in addition to detoxification benefits which include diagnosis and treatment of medical complications.

Transplant Services: Both organ and tissue transplant services are eligible for coverage under all participating managed care plans. Each plan establishes its own certification criteria, coverage and provider network. Contact the respective managed care plan for specific information.

Plan Year Limitations: Certain managed care plans may provide benefit limitations on a **calendar year.** In certain situations, the State's plan year may not coincide with the managed care plan's year.

Transition of Services: If you know you are switching plans and you or your dependents are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, it is imperative that you contact the new plan to coordinate the transition of services for your care.

NCQA Accreditation and Managed Care Plans in Bordering States

One way the quality of managed care plans can be judged is through accreditation by an outside agency. **The National Committee for Quality Assurance (NCQA)** is a leader in accrediting managed care plans. The not-for-profit NCQA prides itself on providing purchasers and consumers of managed care with comparative data on plan quality and value.

The higher the level of the accreditation, the more closely the plan meets NCQA standards. Levels include:

Excellent: This highest accreditation status is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA rigorous requirements for consumer protection and quality improvement. Plans earning this level must also achieve Health Plan Employer Data and Information Set (HEDIS) results, the highest range of national or regional performance.

Commendable: Awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA requirements for consumer protection and quality improvement.

Accredited: Indicates the plan meets most of NCQA basic requirements.

Provisional: Is an indication that a plan's service and clinical quality meet some, but not all, of NCQA basic requirements.

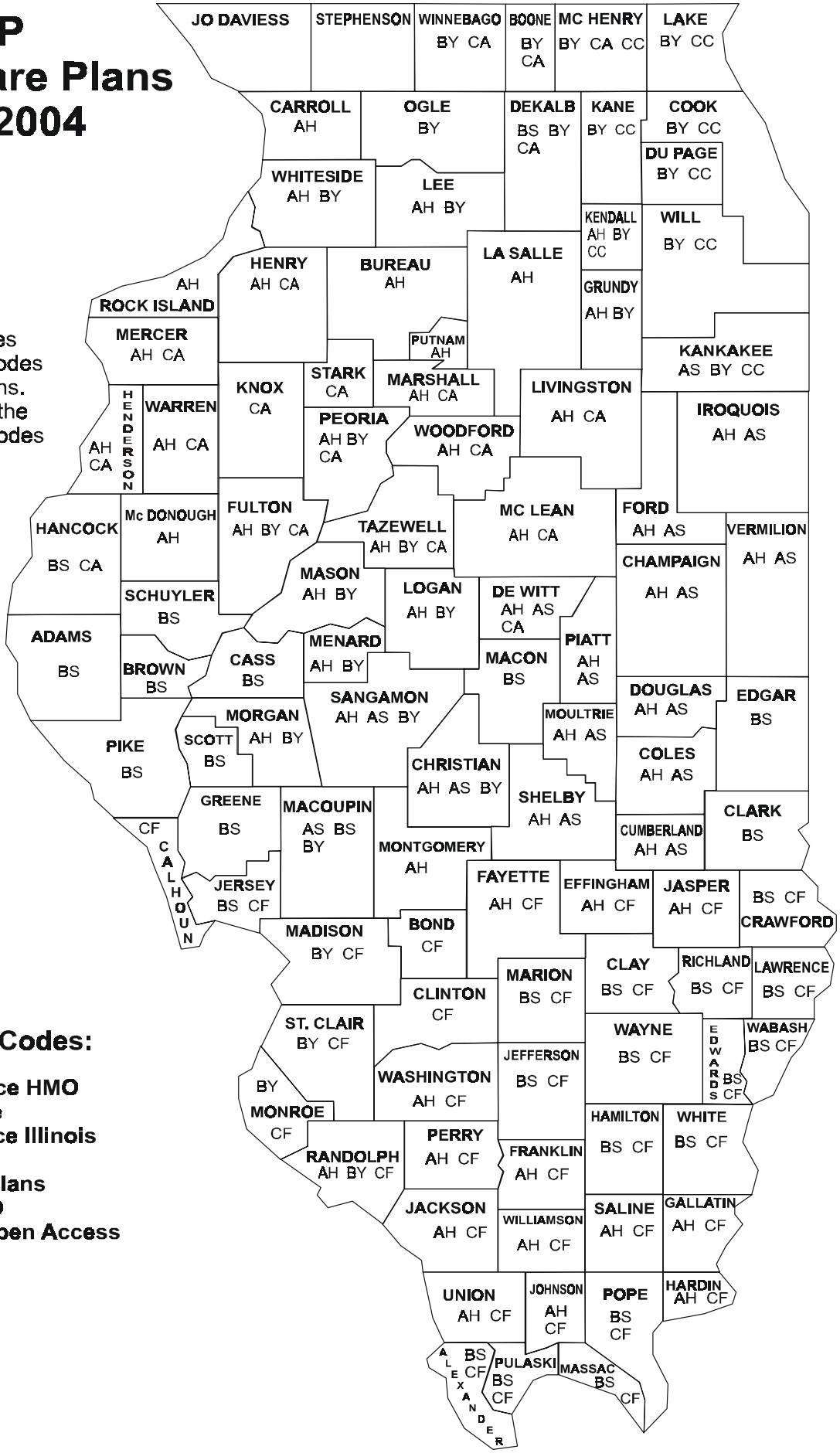
Further information regarding NCQA accreditation, see the chart below or contact NCQA directly at (888) 275-7585 or at their website (http://www.ncqa.org).

Plan Name and Code	Counties in Indiana	Counties in Iowa	Counties in Kentucky	Counties in Missouri	Counties in Wisconsin	NCQA Accreditation
Health Alliance Illinois (Code: BS)	Daviess, Dubois, Gibson, Knox, Martin, Pike, Posey, Spencer, Vanderburgh, Warrick	Lee		Marion, Lewis, Clark		Excellent
Health Alliance HMO (Code: AH)		Scott				Excellent
HealthLink Open Access (Code: CF)	*		*	*		Not Reviewed
HMO Illinois (Code: BY)	Lake, Porter				Kenosha	Excellent
OSF Health Plan (Code: CA)						Excellent
PersonalCare (Code: AS)						Excellent
Unicare HMO (Code: CC)	Lake, Porter					Excellent

* Counties are too numerous to list. Please contact HealthLink for a complete listing.

LGHP Managed Care Plans For FY 2004

The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their codes appear.



HMO and OAP Codes:

AH = Health Alliance HMO
AS = PersonalCare
BS = Health Alliance Illinois
BY = HMO Illinois
CA = OSF Health Plans
CC = UniCare HMO
CF = HealthLink Open Access

The Local Care Health Plan (LCHP)

LCHP is a medical indemnity plan which offers a comprehensive range of benefits. The LCHP Medical Plan Administrator is CIGNA. Under LCHP, plan participants choose any physician or hospital for general or specialty medical services, and receive enhanced benefits by using a LCHP Preferred Provider Organization (PPO) hospital, the CIGNA Healthcare PPO Network, network pharmacies for prescription drugs and mental health/substance abuse network providers.

Plan Year Maximums and Deductibles

The benefits described in this summary represent the major areas of coverage under LCHP. The plan year is July 1 through June 30 of the following year.	
Plan Year Maximum Lifetime Maximum	Unlimited Unlimited
Plan Year Deductible	The plan year deductible is $250 for each covered person.
Additional Deductibles* ***These are in addition to the plan year deductible.**	Each emergency room visit $250 Non-PPO hospital admission $250 Transplant deductible $250 Note: There is no additional deductible for admission to a PPO hospital.
Skilled Nursing Maximum	Benefits are available up to 100 days each plan year. Benefits cease after the 100th day.

Out-of-Pocket Maximums

There are two separate out-of-pocket maximums: a general and a non-PPO hospital. After the out-of-pocket maximum(s) have been met, LCHP pays 100% of eligible charges for the remainder of the plan year up to any benefit maximum. Coinsurance and deductibles count toward one or the other, but not both.

General: **$1,000 per individual** **$2,500 per family per plan year**	**Non-PPO Hospital:** **$4,000 per individual** **$9,000 per family per plan year**

The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits or copayments.
- Mental Health/Substance Abuse benefits, coinsurance or copayments.
- Notification penalties.
- Ineligible charges (amounts over U&C and charges for non-covered services).

LCHP - Medical Plan Coverage

Hospital Services	
LCHP Preferred Provider Organization Hospitals and CIGNA Healthcare PPO Network	90% after annual plan deductible. No admission deductible.
Non-Preferred Provider Organization (PPO) Hospital	• $250 per admission deductible. • If the member resides in Illinois or within 25 miles of a LCHP PPO hospital and the member chooses to use a non-PPO and/or voluntarily travels in excess of 25 miles when a LCHP PPO hospital is available within the same travel distance the plan pays 65% after the annual plan deductible. • If the member resides in Illinois and has no LCHP PPO hospital available within 25 miles and voluntarily chooses to travel further than the nearest LCHP PPO hospital, the plan pays 65% after the annual plan deductible. • If the member does not reside in Illinois or within 25 miles of a LCHP PPO hospital, the plan pays 80% after the annual plan deductible.
Outpatient Services	
Lab/X-ray	80% of Usual & Customary (U&C) after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of U&C after annual plan deductible. Contact the plan administrator for approval prior to obtaining items.
Licensed Ambulatory Surgical Treatment Center	90% after annual plan deductible.
Professional and Other Services	
CIGNA Healthcare PPO Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician & Surgeon Services	80% of U&C after the annual plan deductible for inpatient, outpatient & office visits.
Transplant Services	
Organ and Tissue Transplants	80% of negotiated fee after $250 transplant deductible. Benefits are not available unless approved by the Notification Administrator (Intracorp). To assure coverage, the transplant candidate **must** contact the Notification Administrator prior to beginning evaluation services.

Coordination of Benefits for Medicare Primary Plan Participants

After Medicare Part A pays, LCHP pays 80% of the balance after the LCHP annual plan deductible. After Medicare Part B pays, LCHP pays 80% of the balance after the LCHP annual plan deductible and Medicare Part B annual plan deductible. If the provider does not accept Medicare assignment, LCHP pays 80% of amounts Medicare does not cover, up to the maximum limiting charges set by Medicare.

LCHP - Notification and Penalties

Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility, or for a specified outpatient procedure. Notification is the plan participant's responsibility and is a method to avoid monetary penalties and maximize benefits.

For notification procedures for mental health/substance abuse services, see the Benefits Handbook section entitled Mental Health/Substance Abuse.

Notification is required for all plan participants including those who may no longer have benefits available from other primary payer insurance or Medicare. Allow a minimum of two business days for review. Failure to notify the Notification Administrator within the required time limits will result in a $400 penalty and the risk of incurring non-covered charges for services not deemed to be medically necessary.

A "reference number" will be assigned and should be maintained in the plan participant's records. This number serves as a reference should there be any questions regarding notification. However, it is not a guarantee of benefits.

Upon notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information, evaluate the procedure, setting and anticipated initial length of stay for medical appropriateness, and determine whether a second opinion is required.

Notification is required for the following:

- **Elective Surgical or Non-Emergency Admission** - At least seven days before admission, call the Notification Administrator.
- **Maternity** - It is recommended that the notification process occur as early in the pregnancy as possible in order to enable the Notification Administrator to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. Notification of a maternity admission is not automatic enrollment of the newborn. Contact the Health Plan Representative to enroll the newborn.
- **Skilled Nursing - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home** - At least seven days before admission, call the Notification Administrator. A review will be conducted to determine if the services are skilled in nature.
- **Emergency or Urgent Admission** - The plan participant or physician must phone the Notification Administrator within two business days after the admission.
- **Outpatient Procedures** - It is necessary to call the Notification Administrator before receiving imaging (MRI, PET, SPECT and CAT Scan), allergy testing, colonoscopy and endoscopy services.
- **Potential Transplants** - To ensure maximum benefits are available, potential transplant candidates should provide notification at the first indication that a transplant may be necessary. Benefits are available only if authorized by the Notification Administrator.
- **Infertility Treatment** - A written predetermination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment. This applies to both medical and prescription benefits. Upon submission of the required documentation, a letter of denial or approval will be mailed to the plan participant. Refer to page 47 of your Benefits Handbook for more information. Please allow a minimum of 5 business days from receipt of all necessary documentation by the Notification Administrator to determine if the treatment is approved or denied.

To satisfy the notification requirement, you can call seven days a week, 24 hours a day:

INTRACORP/CIGNA (800) 962-0051
(800) 526-0844
(TDD/TTY)

LCHP - Prescription Drug Plan

Prescription drug benefits are independent of other medical services and are not subject to the plan year deductible or the medical out-of-pocket maximums. The Prescription Drug Plan includes both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription.

Infertility Prescription Benefits - A written pre-determination of benefits must be obtained from the Medical Plan Administrator (CIGNA) prior to beginning infertility treatment. This applies to both medical and prescription benefits (see page 47 of the Benefits Handbook). Upon submission of the required documentation, a letter of denial or approval will be mailed by the Medical Plan Administrator.

The Prescription Drug Plan Administrator must confirm that a pre-determination of benefits has been approved before infertility medication can be dispensed at a retail pharmacy. This may take additional time. If a pre-determination is not on file, the plan participant will be directed to contact the Medical Plan Administrator to start the process; this will slow receipt of any approved medication.

When ordering infertility medication through the Mail Order Pharmacy, a copy of the pre-determination letter from the Medical Plan Administrator must accompany any prescription in order for these medications to be filled. If the approved pre-determination letter is not enclosed with the infertility medication prescription, the member will be directed to contact the Medical Plan Administrator to start the process. This will slow receipt of any approved medication.

In-Network Benefits

The pharmacy network consists primarily of retail pharmacies which accept the copayment and electronically transmit the prescription claim for processing. The Member identification number, which ends in 1401, is printed on the ID card. For the most up-to-date information on network pharmacies, call the Prescription Drug Plan Administrator found on page 36.

In-network benefits when using the Member ID Card/Number:

- No plan year deductibles; no claim forms to file.
- Flat Copayments (1 to 30-day supply):
  - Generic $ 7.00
  - Formulary Brand $14.00
  - Non-Formulary Brand $28.00
- The maximum days supply available at one fill is 60 days. The copayments described above will double for any prescription exceeding 30 days.
- When the pharmacy dispenses a brand drug for any reason, and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment of $7.00.
- If only a brand drug is available, the copayment will be $14.00 or $28.00.
- When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.

When medication is purchased at an in-network pharmacy <u>without</u> presentation of the ID Card/Number, the plan participant will be charged the full retail cost of the medication. A paper claim for reimbursement of the cost must then be sent to the Prescription Drug Plan Administrator. The claim will be processed as if the prescription was filled at an out-of-network pharmacy (see Out-of-Network Benefits).

Out-of-Network Benefits

Prescription drugs may be purchased at out-of-network pharmacies. Plan participants must pay all charges at the time of purchase and file a paper claim form with the Prescription Drug Plan Administrator. Reimbursement will be at the applicable brand or generic **in-network** price minus the appropriate in-network copayment. In most cases, the cost of the prescription drugs

will be higher when not using network pharmacies. Claim forms are available from the Prescription Drug Plan Administrator.

Mail Service Program

Maintenance medications are available through mail order at the following copayments:

– Flat Copayments (90-day supply):

- Generic $14.00
- Formulary Brand $28.00
- Non-Formulary Brand $56.00

Contact the Prescription Drug Plan Administrator for mail order forms and information.

Specialty Pharmacy Services

Some medications are only dispensed from the Prescription Drug Plan's Specialty Pharmacy. This pharmacy specializes in the delivery of medications for specific diseases. The types of medications dispensed from the Specialty Pharmacy are for conditions such as: Multiple Sclerosis, Hepatitis B and C, Arthritis, Immune Deficiency and Hemophilia. Medication is usually shipped within 24 hours of receipt of the request; quantities are limited to 30-days or less. For additional information, contact the Prescription Drug Plan Administrator at www.caremark.com or call 1-800-237-2767.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans. However, the appropriate copayment will always be applied.

Medicare Covered Prescriptions

When a plan participant is enrolled in Medicare Part B and Medicare is primary, Medicare provides coverage for certain prescriptions, including diabetic test strips and lancets. Medicare approved retail pharmacies will submit claims for Medicare covered prescriptions directly to Medicare. At the time of purchase, plan participants will generally be responsible for the 20% not covered by Medicare.

Caremark's Mail Order Pharmacy will also submit claims to Medicare for Medicare covered prescriptions, charging only the 20% of the Medicare allowed amount. This process cannot be initiated until the plan participant has signed an assignment of benefit form and mailed it to the Prescription Drug Plan Administrator. To obtain these forms, contact the Prescription Drug Plan Administrator at 1-866-804-5880.

Upon receipt of the Medicare Explanation of Benefits (EOMB) plan participants may submit a paper claim for any reimbursement due (usually a portion of the 20%). The applicable copayment is always applied.

The Prescription Drug Plan Administrator has established a special Medicare Customer Service Team (866-804-5880) to provide forms and answer questions regarding Medicare Coordination of Benefits. For answers to questions about eligibility for Medicare Part A, Part B, or to apply for Medicare, call the Social Security Administration at 1-800-772-1213 or 1-800-325-0778 (TDD/TTY).

Exclusions

The Plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

LCHP- CIGNA HealthCare PPO Networks

LCHP non-Medicare members have available **nationwide** CIGNA HealthCare PPO providers, hospitals and facilities. An enhanced 90% benefit for professional fees, hospital and facility services is available by using a participating network provider. The questions and answers below provide more information about this benefit feature. If you have additional questions, call the Group Insurance Division, see page 36.

What is the CIGNA HealthCare PPO Network?

The CIGNA HealthCare PPO Network is a nationwide network of physicians, hospitals and facilities that have agreed to participate at negotiated rates offering members an enhanced benefit.

What are the advantages of using a CIGNA HealthCare PPO Network provider?

The advantages of using providers participating in the network are that benefits for covered services are paid at 90% of a negotiated fee and usual and customary limits will not be applied.

How do I access services from a CIGNA HealthCare PPO Network provider?

Just make an appointment with a network provider and present your Local Care Health Plan identification card at the time of service.

What if I do not use a CIGNA HealthCare PPO Network provider?

Standard plan benefits, coinsurance levels, and usual and customary limits apply.

How can I find out which providers are participating in the CIGNA HealthCare PPO Network?

Access the participating provider list on the website at:

http://provider.healthcare.cigna.com/soi.html.
Or, call CIGNA at (800) 962-0051.

LCHP - Hospital Preferred Provider Organizations

Chicagoland Area (Cook, DuPage & Lake Counties)

Advocate Bethany Hospital, Chicago
Advocate Christ Hospital & Med. Ctr., Oak Lawn
Advocate Good Samaritan Hosp., Downers Grove
Advocate Good Shepherd Hospital, Barrington
Advocate Illinois Masonic Medical Center, Chicago
Advocate Lutheran General Hospital, Park Ridge
Advocate South Suburban Hospital, Hazel Crest
Advocate Trinity Hospital, Chicago
Alexian Brothers Medical Ctr., Elk Grove Village

Central DuPage Hospital, Winfield
Children's Memorial Hospital, Chicago
Condell Medical Center, Libertyville
Cook County Hospital, Chicago

Edward Hospital, Naperville
Elmhurst Memorial Hospital, Elmhurst
Evanston Northwestern Healthcare, Evanston

Glen Oaks Hospital, Glendale Heights
Glenbrook Hospital, Glenview
Gottlieb Memorial Hospital, Melrose Park
Grant Community Hospital, Chicago

Highland Park Hospital, Highland Park
Hinsdale Hospital, Hinsdale
Holy Cross Hospital, Chicago
Holy Family Medical Center, Des Plaines

Ingalls Memorial Hospital, Harvey

Jackson Park Hospital, Chicago

LaGrange Memorial Hospital, LaGrange
Lake Forest Hospital, Lake Forest
LaRabida Children's Hospital, Chicago
Little Company of Mary Hospital, Evergreen Park
Loretto Hospital, Chicago
Louis A. Weiss Memorial Hospital, Chicago
Loyola University Medical Center, Maywood

MacNeal Memorial Hospital, Berwyn
Marianjoy Rehabilitation Hospital, Wheaton
Mercy Hospital & Medical Center, Chicago
Methodist Hospital of Chicago, Chicago
Michael Reese Hospital & Medical Ctr., Chicago
Mt. Sinai Hospital, Chicago

Northwest Community Hospital, Arlington Heights
Northwestern Memorial Hospital, Chicago
Norwegian American Hospital, Chicago

Oak Forest Hospital of Cook County, Oak Forest
Oak Park Hospital, Oak Park
Our Lady of the Resurrection Med. Center, Chicago

Palos Community Hospital, Palos Heights
Provena St. Therese Medical Center, Waukegan
Provident Hospital of Cook County, Chicago

Rehabilitation Institute of Chicago, Chicago
Resurrection Medical Center, Chicago
RML Specialty Hospital, Hinsdale
Roseland Community Hospital Assn., Chicago
Rush North Shore Medical Center, Skokie
Rush Pres-St. Luke's Medical Center, Chicago

Schwab Rehabilitation Hospital, Chicago
South Shore Hospital, Chicago
SSM St. Francis Hosp. & Hlth. Ctr., Blue Island
St. Alexius Medical Center, Hoffman Estates
St. Anthony Hospital, Chicago
St. Bernard Hospital & Health Care Center, Chicago
St. Elizabeth Hospital, Chicago (closing in late 2003)
St. Francis Hospital, Evanston
St. James Hospital & Health Center, Chicago Hts.
St. James Hospital & Health Center, Olympia Fields
St. Joseph Hospital, Chicago
St. Margaret Mercy Healthcare Ctr., Hammond, IN
St. Margaret Mercy Healthcare Center, Dyer, IN
St. Mary of Nazareth Hospital Center, Chicago
Swedish Covenant Hospital, Chicago

The Community Hospital, Munster, IN
Thorek Hospital & Medical Center, Chicago

University of Chicago Hospital, Chicago
University of Illinois Medical Center, Chicago

Victory Memorial Hospital, Waukegan

West Suburban Hospital Medical Center, Oak Park
Westlake Community Hospital, Melrose Park

LCHP - Hospital Preferred Provider Organizations

Northern Illinois

CGH Medical Center, Sterling
Children's Hospital of Wisconsin, Milwaukee
Copley Medical Center, Aurora

Delnor Community Hospital, Geneva
DeWitt Community Hospital, DeWitt, IA

Freeport Memorial Hospital, Freeport

Genesis Medical Center East, Davenport, IA
Genesis Medical Center West, Davenport, IA

Hammond-Henry District Hospital, Geneseo
Harvard Memorial Hospital, Inc., Harvard

Illini Hospital, Silvis

Katherine Shaw Bethea Hospital, Dixon
Kishwaukee Community Hospital, DeKalb

Memorial Medical Center, Woodstock
Mendota Community Hospital, Mendota
Mercer County Hospital, Aledo
Mercy Medical Center, Clinton, IA
Morris Hospital, Morris
Morrison Community Hospital, Morrison

Northern Illinois Medical Center, McHenry

Provena Mercy Center, Aurora
Provena St. Joseph Hospital, Elgin
Provena St. Joseph Medical Center, Joliet
Provena St. Mary's Hospital, Kankakee

Riverside Medical Center, Kankakee
Rochelle Community Hospital, Rochelle
Rockford Memorial Hospital, Rockford

Saint Anthony Medical Center, Rockford
Sherman Hospital, Elgin
Silver Cross Hospital, Joliet
St. Anthony Medical Center, Crown Point, IN
Swedish American Hospital, Rockford

The Monroe Clinic, Monroe, WI
Trinity Med. Ctr., North Campus, Davenport, IA
Trinity Medical Center, 7th St., Moline
Trinity Medical Ctr., West Campus, Rock Island

Univ. of Wisconsin Hospital, Madison, WI

Valley West Community Hospital, Sandwich

LCHP - Hospital Preferred Provider Organizations

Central Illinois

Abraham Lincoln Memorial Hospital, Lincoln
Blessing Hospital, Quincy
BroMenn Regional Medical Center, Bloomington

Carle Foundation Hospital, Urbana
Carlinville Area Hospital, Carlinville
Community Hospital of Ottawa, Ottawa
Comm. Med. Ctr. of Western Illinois, Monmouth
Community Memorial Hospital, Staunton

Decatur Memorial Hospital, Decatur
Doctors Hospital, Springfield
Dr. John Warner Hospital, Clinton

Eureka Community Hospital, Eureka

Galesburg Cottage Hospital, Galesburg
Gibson Community Hospital, Gibson City
Graham Hospital, Canton

Hillsboro Area Hospital, Hillsboro
Hoopeston Comm. Memorial Hosp., Hoopeston

Illini Community Hospital, Pittsfield
Illinois Valley Community Hospital, Peru
Iroquois Memorial Hospital, Watseka

Jersey Community Hospital, Jerseyville
Julia Rackley Perry Memorial Hospital, Princeton

Keokuk Area Hospital, Keokuk, IA

Mason District Hospital, Havana
McDonough District Hospital, Macomb
Memorial Hospital Association, Carthage
Memorial Medical Center, Springfield
Methodist Medical Center of Illinois, Peoria

Pana Community Hospital, Pana
Paris Community Hospital, Paris
Passavant Memorial Area Hospital, Jacksonville
Pekin Hospital, Pekin
Proctor Hospital, Peoria
Provena Covenant Medical Center, Urbana
Provena United Samaritans Med. Ctr., Danville

Saint Francis Medical Center, Peoria
Saint James Hospital, Pontiac
Sarah Bush Lincoln Health Center, Mattoon
Sarah D. Culbertson Mem. Hosp., Rushville
Shelby Memorial Hospital, Shelbyville
St. Francis Hospital, Litchfield
St. John's Hospital, Springfield
St. Joseph Medical Center, Bloomington
St. Margaret's Hospital, Spring Valley
St. Mary Medical Center, Galesburg
St. Mary's Hospital, Decatur
St. Mary's Hospital, Streator
St. Vincent Memorial Hospital, Taylorville

The John & Mary E. Kirby Hospital, Monticello
Thomas H. Boyd Memorial Hospital, Carrollton

LCHP - Hospital Preferred Provider Organizations

Southern Illinois and Metro-East

Alton Memorial Hospital, Alton
Anderson Hospital, Maryville

Barnes-Jewish Hospital, St. Louis
Barnes-Jewish St. Peter's Hospital, St. Peters, MO
Barnes-Jewish West County Hospital, Creve Coeur

Christian Hospital, NE, St. Louis
Christian Hospital, NW, Florissant
Clay County Hospital, Flora
Crawford Memorial Hospital, Robinson
Crossroads Comm. Hospital, Mt. Vernon

Des Peres Hospital, St. Louis

Edward A. Utlaut Hospital, Greenville

Fairfield Memorial Hospital, Fairfield
Fayette County Hospital, Vandalia
Ferrell Hospital, Eldorado
Forest Park Hospital, St. Louis

Gateway Regional Medical Center, Granite City
Good Samaritan Hospital, Vincennes, IN
Good Samaritan R.H.C., Mt. Vernon

Hamilton Memorial Hospital, McLeansboro
Hardin County General Hospital, Rosiclare
Harrisburg Medical Center, Harrisburg
Heartland Regional Medical Center, Marion
Herrin Hospital, Herrin

Lawrence County Memorial Hospital, Lawrenceville
Lourdes Hospital, Paducah, KY

Marshall Browning Hospital, DuQuoin
Massac Memorial Hospital, Metropolis
Memorial Hospital, Belleville
Memorial Hospital, Chester
Memorial Hospital of Carbondale, Carbondale
Missouri Baptist Medical Center, St. Louis

Pinckneyville Community Hosp., Pinckneyville

Red Bud Hospital, Red Bud
Richland Memorial Hospital, Olney

Saint Anthony's Health Center, Alton
Saint Clare's Hospital, Alton
Saint Francis Medical Center, Cape Girardeau, MO
Salem Township Hospital, Salem
South Pointe Hospital, St. Louis
Southeast Missouri Hospital, Cape Girardeau, MO
Sparta Community Hospital, Sparta
SSM Cardinal Glennon Children's Hosp., St. Louis
SSM DePaul Health Center, Bridgeton, MO
SSM Rehabilitation Institute, St. Louis (all sites)
SSM St. Mary's Health Center, Richmond Heights
St. Alexius Hospital, St. Louis
St. Anthony's Medical Center, St. Louis
St. Anthony's Memorial Hospital, Effingham
St. Elizabeth's Hospital, Belleville
St. John's Mercy Medical Center, St. Louis
St. Joseph's Hospital, Highland
St. Joseph's Hospital, Breese
St. Joseph Memorial Hospital, Murphysboro
St. Louis Children's Hospital, St. Louis
St. Louis University Hospital, St. Louis
St. Luke's Episcopal Presbyterian Hosp., Chesterfield
St. Mary's Hospital, Centralia
St. Mary's Hospital of E. St. Louis, E. St. Louis, IL

Touchette Regional Hospital, Centreville

Union County Hospital District, Anna

Wabash General Hospital, Mt. Carmel
Washington County Hospital, Nashville
White County Medical Center, Carmi

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 14, 2003

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) is charged with the administration of the self-funded plans available through the State Employees Group Insurance Act of 1971, including the Local Care Health Plan and the Local Government Dental Plan. The term "we" in this Notice means the Bureau and our Business Associates (health plan administrators).

We are required by federal and state law to maintain the privacy of your Protected Health Information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices concerning your PHI. For uses and disclosures not covered by this Notice, we will seek your written authorization. You may revoke an authorization at any time; however, the revocation will only affect future uses or disclosures.

The Bureau contracts with Business Associates to provide services including claim processing, utilization review, behavioral health services and prescription drug benefits. You may not have coverage with all of our Business Associates. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on behalf of the Bureau in performing their respective functions. When we seek help from individuals or entities who are not part of the Bureau in our treatment, payment, or health care operations activities, we require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule. CIGNA HealthCare is the Medical Plan Administrator. Intracorp (a CIGNA HealthCare Affiliate) is the Notification and Medical Case Management Administrator. Caremark is the Pharmacy Benefit Plan Administrator. Magellan Behavioral Health is the Mental Health and Substance Abuse Plan Administrator. CompBenefits is the Dental Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a Notice from the respective plan administrator regarding its Privacy Practices.

How We May Use or Disclose Your PHI

Treatment: We may use or disclose PHI to health care providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party.

We may also use or disclose PHI to contact you and tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.

Payment: We use and disclose PHI to process claims and make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim for payment. The claim includes information that identifies you, your diagnosis, and your treatment.

Health Care Operations: We use or disclose PHI for health care operations. For example, we may use your PHI for customer service activities and to conduct quality assessment and improvement activities.

Appointment Reminders: Through a Business Associate, we may use or disclose PHI to remind you of an upcoming appointment.

Legal Requirements

We may use and disclose PHI **as required or authorized by law.** For example, we may use or disclose your PHI for the following reasons:

Public Health: We may use and disclose PHI to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

Health Oversight Activities: We may use and disclose PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose PHI in judicial and administrative proceedings. In some cases, the party seeking the information may contact you to get your authorization to disclose your PHI.

Law Enforcement: We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Organ Procurement: We may use or disclose PHI to an organ procurement organization or others involved in facilitating organ, eye, or tissue donation and transplantation.

Release of Information to Family Members: In an emergency, or if you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those who are responsible for transporting inmates, and others.

Research: You will need to sign an authorization form before we use or disclose PHI for research purposes except in limited situations where

special approval has been given by an Institutional Review or Privacy Board. For example, if you want to participate in research or a clinical study, an authorization form must be signed.

Fundraising and Marketing: We do not undertake fundraising activities. We do not release PHI to allow other entities to market products to you.

Plan Sponsors: Your employer is not permitted to use the PHI for any purpose other than the administration of your benefit plan. If you are enrolled through a unit of local government, we may disclose summary PHI to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you participate.

Illinois Law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless Illinois law allows us to make the specific type of use or disclosure without your authorization.

Your Rights

You have certain rights under federal privacy laws relating to your PHI. To exercise these rights, you must submit your request in writing to the appropriate plan administrator. These plan administrators are as follows:

For the Medical Plan Administrator and Notification/Medical Case Management Benefits:

CIGNA HealthCare
Privacy Office
P.O. Box 5400
Scranton, PA 18503
800-762-9940

For Pharmacy Benefits:

Caremark, Inc.
Privacy Officer
2211 Sanders Road
Northbrook, IL 60062
800-559-4700

For Mental Health and Substance Abuse Benefits:

Magellan Behavioral Health
Privacy Official
10 S. Riverside Plaza
11th Floor
Chicago, IL 60604
800-424-4020

For Dental Plan Benefits:

CompBenefits
Privacy Officer
100 E. Mansell Court E.
Suite 400
Roswell, GA 30076
800-342-5209

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home or that we send your mail to another address. If your request is put in writing and is reasonable, we will accommodate it. If you feel you may be in danger, just tell us you are "in danger" and we will accommodate your request.

Inspect and Access: You have a right to inspect information used to make decisions about you. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies. If you ask us to mail your records, we may also charge you a fee for mailing the records.

Amendment of your Records: If you believe there is an error in your PHI, you have a right to make a request that we amend your PHI. We are not required to agree with your request to

amend. We will send you a letter stating how we handled your request.

Accounting of Disclosures: You have a right to receive an Accounting of Disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or disclosures made pursuant to your authorization. We may charge you a fee if you request more than one Accounting in a 12-month period.

Copy of Notice and Changes to the Notice: You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. Changes to the Notice are applicable to the health information we already have. If we materially change this Notice, you will receive a new Notice within sixty (60) days of the material change. You can also access a revised Notice on our website at: www.state.il.us/cms/employee/grpins/.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer of the respective Plan Administrator. If the Privacy Officer does not handle your complaint or request adequately, please contact the Central Management Services Privacy Officer at the Office of the Chief Counsel, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 217-782-9669. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Dental Plan

Local Government Dental Plan (LGDP)

All LGHP members are automatically enrolled in LGDP. **LGDP is administered by CompBenefits, formerly known as CompDent.** Under LGDP, you may go to any dentist and receive benefits for an extensive range of services. LGDP reimburses covered services at a pre-determined maximum allowable scheduled amount. Members are responsible for any charges over the scheduled amount. For a detailed description of your dental plan benefits, see the schedule of benefits on the following pages. Dental plan questions should be directed to **CompBenefits, at (800) 999-1669, or (312) 829-1298 (TDD/TTY).**

LGDP Benefits

Plan Design	Local Government Dental Plan (LGDP)
Annual Deductible	$50 individual plan deductible for dental services other than those listed as "preventive or diagnostic" on the Schedule of Benefits in the Benefits Handbook.
Maximum Benefit Limit	$1,200 per person per plan year after plan deductible. $2,000 combined maximum, after deductible, on prosthetic, periodontic, surgical extraction and general anesthesia services accumulated every five years.
Maximum Benefit Level for Child Orthodontics (under age 19)	$1,500 lifetime maximum depending on length of treatment after plan deductible. Orthodontic benefits count toward maximum annual benefits above. **Contact CompBenefits for a pre-treatment estimate.**
Claim forms	Required
Dentist selection	Choice of provider

Maximum benefits apply after required deductibles are met. All benefits are subject to LGDP exclusions (see page 77 of the Benefits Handbook).

FY2004 LGDP - Schedule of Benefits

Diagnostic Services	Maximum Benefit	Code
Periodic Oral Examination	$ 15	D0120
Limited Oral Evaluation (specific oral health problem)	$ 15	D0140
Comprehensive Oral Examination	$ 23	D0150
Radiographs/Diagnostic Imaging		
Intraoral Complete Series (once in a period of three plan years, including bitewings)	$ 50	D0210
Intraoral - Periapical First Film	$ 11	D0220
Intraoral - Periapical Each Additional Film	$ 8	D0230
Bitewing Single Film	$ 9	D0270
Bitewing Two Films	$ 17	D0272
Bitewing Four Films	$ 26	D0274
Panoramic Film, (once in a period of three plan years)	$ 42	D0330
Preventive Services	**Maximum Benefit**	**Code**
Prophylaxis Adult - Twice each plan year	$ 34	D1110
Prophylaxis Child - Twice each plan year	$ 23	D1120
Topical Application of Fluoride - Child **(including** prophylaxis) (once each plan year, covered through age 18 only)	$ 37	D1201
Topical Application of Fluoride - Child **(not including** prophylaxis) (once each plan year, covered through age 18 only)	$ 14	D1203
Sealant - per tooth, covered through age 18 only	$ 23	D1351
Space Maintainers (Passive Appliances)		
Fixed Unilateral	$ 72	D1510
Fixed Bilateral	$ 81	D1515
Removable Unilateral	$ 72	D1520
Removable Bilateral	$ 81	D1525

Restorative Services	Maximum Benefit	Code
Amalgam Restorations		
Amalgam One Surface, Primary or Permanent	$ 39	D2140
Amalgam Two Surfaces, Primary or Permanent	$ 56	D2150
Amalgam Three Surfaces, Primary or Permanent	$ 64	D2160
Amalgam Four or more Surfaces, Primary or Permanent	$ 71	D2161
Resin-Based Composite Restorations		
One Surface, Anterior	$ 46	D2330
Two Surfaces, Anterior	$ 59	D2331
Three Surfaces, Anterior	$ 73	D2332
Four or more Surfaces or involving incisal angle (anterior)	$ 79	D2335
One Surface Posterior	$ 81	D2391
Two Surface Posterior	$112	D2392
Three Surface Posterior	$139	D2393
Four or More Surfaces, Posterior	$172	D2394
Crowns/Single Restorations Only		
Crown-Resin (laboratory)	$ 86	D2710
Crown-Resin with high noble metal	$250	D2720
Crown-Resin predominantly base metal	$215	D2721
Crown-Resin with noble metal	$241	D2722
Crown-Porcelain/Ceramic Substrate	$253	D2740
Crown-Porcelain fused to high noble metal	$254	D2750
Crown-Porcelain fused to predominantly base metal	$237	D2751
Crown-Porcelain fused to noble metal	$246	D2752
Crown-3/4 cast predominately base metal	$252	D2781
Crown-Full cast high noble metal	$227	D2790
Crown-Full cast predominantly base metal	$233	D2791
Crown-Full cast noble metal	$246	D2792
Other Restorative Services		
Recement Inlay	$ 17	D2910
Recement Crown	$ 18	D2920
Prefabricated stainless steel Crown (primary tooth)	$ 58	D2930
Prefabricated stainless steel Crown (permanent tooth)	$ 62	D2931
Prefabricated Resin Crown	$ 54	D2932

Endodontics	Maximum Benefit	Code
Pulp Capping		
Pulp Cap - Direct (excluding final restoration)	$ 26	D3110
Pulp Cap - Indirect (excluding final restoration)	$ 20	D3120
Pulpotomy - Therapeutic (excluding final restoration)	$ 62	D3220
Root Canal Therapy (include intra-operative radiographs)		
Anterior (excludes final restoration)	$244	D3310
Bicuspid (excludes final restoration)	$304	D3320
Molar (excludes final restoration)	$410	D3330
Retreatment of Previous Root Canal Therapy		
Anterior	$266	D3346
Bicuspid	$316	D3347
Molar	$432	D3348

Periodontics	Maximum Benefit	Code
Gingivectomy/Gingivoplasty		
Per quadrant	$155	D4210
Per tooth	$ 33	D4211
Gingival Flap Procedure		
Per quadrant - includes root planning	$155	D4240
Gingival Flap - including root planning, 1-3 teeth per quadrant	$117	D4241
Osseous Surgery (including flap entry and closure)		
Per quadrant	$224	D4260
Bone Replacement Graft		
First site in quadrant	$228	D4263
Each additional site in quadrant	$173	D4264
Pedicle Soft Tissue Graft	$138	D4270
Free Soft Tissue Graft	$178	D4271
Provisional Splinting		
Intracoronal	$ 73	D4320
Extracoronal	$ 84	D4321
Periodontal Scaling and Root Planing		
Per quadrant	$ 70	D4341

Periodontics (continued)	Maximum Benefit	Code
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	$ 35	D4355
Periodontal Maintenance Procedure		
Following active therapy	$ 28	D4910
Unscheduled Dressing Change	$ 14	D4920
Prosthodontics	**Maximum Benefit**	**Code**
Removable Prosthetics		
Complete Denture - Maxillary	$523	D5110
Complete Denture - Mandibular	$523	D5120
Immediate Denture - Maxillary	$442	D5130
Immediate Denture - Mandibular	$460	D5140
Partial Dentures (removable)		
Maxillary Partial Denture - resin base (conventional clasps, rests and teeth)	$442	D5211
Mandibular Partial Denture - resin base (conventional clasps, rests and teeth)	$501	D5212
Maxillary Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth)	$529	D5213
Mandibular Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth)	$540	D5214
Unilateral, Partial Denture, Removable - one piece cast metal (includes clasps and teeth)	$173	D5281
Adjustments to Dentures		
Adjust complete denture - Maxillary	$ 25	D5410
Adjust complete denture - Mandibular	$ 25	D5411
Adjust partial denture - Maxillary	$ 25	D5421
Adjust partial denture - Mandibular	$ 25	D5422
Repairs to Complete Dentures		
Repair broken complete denture base	$ 48	D5510
Replace missing or broken teeth - complete denture (each tooth)	$ 44	D5520
Repairs to Partial Dentures		
Repair resin denture base	$ 48	D5610
Repair cast framework	$ 62	D5620
Repair or replace broken clasp	$ 54	D5630
Replace broken teeth - per tooth	$ 41	D5640
Add tooth to existing partial denture	$ 59	D5650
Add clasp to existing partial denture	$ 77	D5660
Denture Rebase Procedure		
Rebase complete maxillary denture	$179	D5710
Rebase complete mandibular denture	$179	D5711
Rebase maxillary partial denture	$179	D5720
Rebase mandibular partial denture	$179	D5721

Prosthodontics (continued)	Maximum Benefit	Code
Denture Reline Procedure		
Reline complete maxillary denture (chairside)	$ 109	D5730
Reline complete mandibular denture (chairside)	$ 109	D5731
Reline maxillary partial denture (chairside)	$ 109	D5740
Reline mandibular partial denture (chairside)	$ 109	D5741
Reline complete maxillary denture (laboratory)	$154	D5750
Reline complete mandibular denture (laboratory)	$154	D5751
Reline maxillary partial denture (laboratory)	$154	D5760
Reline mandibular partial denture (laboratory)	$154	D5761
Fixed Partial Denture Pontics		
(Each retainer and each pontic constitutes a unit in a fixed partial denture)		
Pontic-Cast high noble metal	$248	D6210
Pontic-Cast predominantly base metal	$219	D6211
Pontic-Cast noble metal	$224	D6212
Pontic-Porcelain fused to high noble metal	$249	D6240
Pontic-Porcelain fused to predominantly base metal	$227	D6241
Pontic-Porcelain fused to noble metal	$237	D6242
Pontic-Resin with high noble metal	$234	D6250
Pontic-Resin with predominantly base metal	$227	D6251
Pontic-Resin with noble metal	$257	D6252
Fixed Partial Denture Retainers - Crowns		
Crown-Resin with high noble metal	$245	D6720
Crown-Resin with predominantly base metal	$230	D6721
Crown-Resin with noble metal	$211	D6722
Crown-Porcelain fused to high noble metal	$250	D6750
Crown-Porcelain fused to predominantly base metals	$232	D6751
Crown-Porcelain fused to noble metal	$231	D6752
Crown-3/4 cast high noble metal	$240	D6780
Crown-Full cast high noble metal	$245	D6790
Crown-Full cast predominantly base metal	$230	D6791
Crown-Full cast noble metal	$234	D6792
Other Fixed Partial Denture Services		
Recement Fixed Partial Denture	$ 23	D6930
Fixed Partial Denture Repair, by report	$ 45	D6980

Oral Surgery	Maximum Benefit	Code
Extractions		
Coronal Remnants - Deciduous Tooth	$74	D7111
Extraction, Erupted Tooth or Exposed Root (elevation or forceps removal)	$70	D7140
Surgical Extraction		
(Includes local anesthesia, suturing if needed, and routine postoperative care)		
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 50	D7210
Removal of impacted tooth - soft tissue	$ 67	D7220
Removal of impacted tooth - partially bony	$ 90	D7230
Removal of impacted tooth - completely bony	$107	D7240
Removal of impacted tooth - completely bony with unusual surgical complications	$121	D7241
Surgical removal of residual tooth roots (cutting procedure)	$ 46	D7250
Other Surgical Procedures		
Biopsy of oral tissue - hard (bone/tooth)	$ 66	D7285
Biopsy of soft tissue - soft (all others)	$ 57	D7286
Alveoloplasty in conjunction with extractions, per quadrant	$ 46	D7310
Alveoloplasty not in conjunction with extractions, per quadrant	$ 62	D7320
Frenulectomy - separate procedure	$ 83	D7960

Adjunctive General Services	Maximum Benefit	Code
Surgical Incision		
Palliative (emergency) treatment of dental pain (minor procedure)	$ 12	D9110
Miscellaneous Services		
Occlusal guards, by report	$110	D9940
Occlusal adjustment, limited	$ 39	D9951
Occlusal adjustment, complete	$ 77	D9952
Anesthesia **General Anesthesia and Intravenous Sedation will be covered only if a qualified medical condition exists with supporting documentation from the patient's medical provider.**		
General anesthesia - first 30 minutes	$156	D9220
General anesthesia - each additional 15 minutes	$ 61	D9221
Intravenous sedation/analgesia - first 30 minutes	$180	D9241
Intravenous sedation/analgesia - each additional 15 minutes	$ 75	D9242

Vision Plan

Eye examinations are an important part of your overall health, protecting your visual wellness and providing early detection of serious health conditions. The vision plan provides coverage for an eye exam, lenses and a frame or contact lenses once every two years.

Eligibility

All Members and dependents covered by any of the health plans offered by the Local Government Health Plan are eligible for the vision care benefit.

Coordination of Benefits

You may coordinate your vision benefits with any other vision coverage you may have available to you. Contact the Vision Plan Administrator for details.

Schedule of Benefits

Service	In-Network Benefit	Out-of-Network Benefit
Exam	100% coverage, less $10 copayment	Covered up to $20
Lenses *		
Single	100% coverage, less $10 copayment	Covered up to $20
Bifocal	100% coverage, less $10 copayment	Covered up to $30
Trifocal	100% coverage, less $10 copayment	Covered up to $30
Frames **	100% coverage, less $10 copayment for frames within the benefit selection	Covered up to $20
Contact Lenses Medically Necessary ***	100% coverage, less $20 copayment	Covered up to $70
Contact Lenses Elective		
Hard or Soft Daily Wear	100% coverage, less $50 copayment****	Covered up to $70
Gas Permeable	100% coverage, less $50 copayment****	Covered up to $70
Others (all other contact lenses, including disposable lenses)	$70 allowance *****	Covered up to $70

Lenses – Plan participants pay for optional lens enhancements. In-network doctors will provide discounted rates for optional lens enhancements.

** **Frames –** For frames outside of the benefit selection, additional charges are discounted and paid by the plan participants. In-network doctors will provide discounted rates for frames outside the benefit selection.

*** **Medically Necessary Contact Lenses –** Prescribed for one of the following conditions: following cataract surgery; to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; with certain conditions of Anisometropia (significant difference in correction between the two eyes); or, with certain conditions of Keratoconus (degenerative disease of the cornea). The provider must obtain prior approval from the Vision Plan Administrator for medically necessary contact lenses.

**** **Contact Lenses –** Elective contact lenses may be chosen instead of glasses. The benefit is applied toward the cost of contact lenses. All other costs, such as the doctor's professional fees for fitting and evaluation services are not covered by the benefit and are the Member's responsibility.

***** **Others** – The benefit is applied toward the cost of the contact lenses. All other costs, such as the doctor's professional fees for fitting and evaluation services are included in the $70 allowance.

Frequency of Benefits

Each benefit component is available once every 24 months from the last time the benefit component was used. Each benefit component is independent and may be obtained at separate times and from separate providers. For example, a Member may receive an eye examination from one provider and purchase new frames from a different provider.

In-Network Services

- **Here are the steps to follow:**
  - Select a provider.

    To obtain vision care services, call a participating doctor or the Vision Plan Administrator, see page 36.
  - Schedule an appointment.

    Call the doctor to make an appointment. Identify yourself as a Member in the LGHP Vision Plan. In-network providers will contact the Vision Plan Administrator to verify eligibility, plan coverage and obtain authorization for services and materials.
  - Use your benefit.

    Materials and services obtained from an in-network provider will be reimbursed at the in-network benefit level. At the time of service, applicable copayment and any additional charges must be paid.

Out-of-Network Services

Covered services or materials may be obtained from any licensed optometrist, ophthalmologist or optician. However, if an out-of-network provider is used, the provider must be paid in full and reimbursement of benefits must be requested by the Member. To file for reimbursement, send the Vision Plan Administrator an itemized receipt along with a letter requesting reimbursement for services. Reimbursement up to the maximum of out-of-network amounts will be paid.

All receipts should be filed promptly, but no later than one year from the ending date of the plan year in which the charge was incurred. Reimbursement benefits are made directly to the covered Member and are not assignable to the provider. Exams and eye wear obtained from out-of-network providers are in place of obtaining services from in-network providers and are subject to the same plan limitations.

For More Information

For more information, contact the Vision Plan Administrator at www.vsp.com or see page 36 for plan administrator information.

Plan Administrators

Only **general** plan questions should be directed to the CMS Group Insurance Division or your Health Plan Representative. Direct all specific claim inquiries to the plan administrators.

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Phone Numbers
Local Care Health Plan (LCHP) Medical Plan Administrator	Medical service information, claim forms, ID cards, claim filing/resolution , and pre-determination of benefits.	**CIGNA** Group Number 2457474 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com.soi.html
LCHP Notification and Medical Case Management Administrator	Notification prior to hospital services. Non-compliance penalty of $400 applies. See page 15 for more information.	**Intracorp, Inc.** (no address required)	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com.soi.html
LCHP Prescription Drug Plan Administrator	Information on prescription drug coverage, pharmacy network, mail order drug, specialty pharmacy, ID cards and claim forms filing.	**Caremark, Inc.** Group Number 1401 **Paper Claims:** P.O. Box 686005 San Antonio, TX 78268-6005 **Mail Order Prescriptions:** P.O. Box 7624 Mt. Prospect, IL 60056-7624	(866) 212-4751 (nationwide) (800) 231-4403 (TDD/TTY) www.caremark.com
Member Assistance Program - LCHP MH/SA Plan Administrator	Mental Health and Substance Abuse notification, authorization, claim forms and claim filing/resolution.	**Magellan Behavioral Health** Group Number 2457474 P.O. Box 909782 Chicago, IL 60690	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanAssist.com
Local Government Dental Plan (LGDP) Administrator	Dental services, claim forms, ID cards and filing.	**CompBenefits** Group Number 960 P.O. Box 4721 Chicago, IL 60680-4721	(800) 999-1669 (312) 829-1298 (TDD/TTY) www.compbenefits.com
Vision Plan Administrator	Vision services, benefits,network providers, claim forms and filing.	**Vision Service Plan (VSP)** P.O. Box 997105 Sacramento, CA 95899-7105	(800) 877-7195 (800) 428-4833 (TDD/TTY) www.vsp.com
General Information	General information on thelocal government health plans or other benefits.	**CMS Group Insurance Division** 600 Stratton Building Springfield, IL 62706	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY

Healthcare Plan Name/Administrator	Toll-Free Telephone Number	TDD / TTY Number	Web Site Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356, ext 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com
OSF Health Plan	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org
Unicare HMO	(888) 234-8855	(312) 234-7770	www.unicare.com

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Bureau of Benefits
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